Medi-Cal DRG Payment Method

Frequently Asked Questions for FY 2015-16

Beginning July 1, 2013, Medi-Cal has paid for most hospital inpatient services received by fee-for-service beneficiaries using diagnosis related groups (DRGs). This FAQ provides information applicable to FY 2015-16, which is Year 3 of the DRG payment method. For information about FY 2013-14 and FY 2014-15 or the payment method in general, see the Department of Health Care Services (DHCS) DRG webpage at http://www.dhcs.ca.gov/provgovpart/Pages/DRG.aspx. *Please note that this FAQ document does not supersede applicable laws, regulations or policies.*

OVERVIEW QUESTIONS

1. What is the Medi-Cal DRG project?

As directed by the California legislature, on July 1, 2013, DHCS implemented a new method of paying for hospital inpatient services in the fee-for-service (FFS) Medi-Cal program. The new method is based on All Patient Refined Diagnosis Related Groups (APR-DRGs).

2. How were hospitals paid prior to the DRG implementation?

From 1983 to 2013, hospitals were paid under the Selective Provider Contracting Program (SPCP). "Contracted" hospitals negotiated a per diem payment rate with the State (previously, the California Medical Assistance Commission). Non-contracted hospitals were reimbursed based on interim rates using a cost-to-charge ratio and subject to a cost settlement process.

3. Is there a transition period?

Yes. The DRG-based payment method is being phased in over a three-year period with the changes fully implemented in the fourth year (FY 2016-17), similar to what Medicare does with major payment changes. See Question 12 for details.

4. Which hospitals are paid by DRG?

DRG payment applies to general acute care hospitals, including out-of-state hospitals and hospitals designated by Medicare as critical access hospitals and long-term care hospitals. Psychiatric hospitals, alcohol and drug rehabilitation facilities, and designated public hospitals (such as the University of California) are outside the scope of DRG-based payment. With regard to rehabilitation hospitals and services, see Question 32. Non-designated public hospitals (NDPHs) transitioned to DRG payment as of January 1, 2014.

5. What services are affected?

For affected hospitals, DRG payment affects all inpatient hospital services except:

- Psychiatric stays, regardless of whether they are in a distinct-part unit or not. Psychiatric stays are paid for by the counties.
- Medi-Cal managed care stays (see Question 7)
- Physical rehabilitation stays (see Question 32)

- Administrative days (see Question 33)

6. Do DRGs affect CCS and GHPP patients?

Claims for beneficiaries who have eligibility under California Children's Services (CCS) or the Genetically Handicapped Person Program (GHPP) are priced using the DRG method. This is true regardless of whether the beneficiaries also have Medi-Cal FFS or Medi-Cal managed care (in CCS carve out counties only). See Question 28.

7. Are payments by Medi-Cal managed care plans affected?

The primary impact to Medi-Cal managed care plans (MCPs) is on payment for emergency and post-stabilization inpatient services provided to MCP enrollees by general acute care hospitals that are not part of the MCP's contracted provider network. MCPs are responsible for calculating out-of-network rates consistent with DRG pricing utilized in Medi-Cal fee-for-service inpatient acute care reimbursement. For each hospital, MCPs should use the statewide (wage adjusted) DRG base rate, regardless of whether a hospital receives a transition rate for Medi-Cal FFS payment. The statewide DRG rates are shown on the hospital characteristics table in the DRG Pricing Calculator available on the DHCS DRG webpage at http://www.dhcs.ca.gov/provgovpart/Pages/DRG.aspx. Calculation of DRG payment then follows the same logic described in Question 9.

MCPs should also use the DRG payment method in pricing emergency and post-stabilization services provided by University of California hospitals and other designated public hospitals (DPHs), if those hospitals are outside the MCP's network. This is the only situation in which the DRG payment method affects DPHs.

The DRG-based method does not affect MCP contracts with network hospitals or arrangements for elective admissions to out-of-network hospitals.

An All Plan Letter *Replacement of Rogers Rate 13-004* dated February 12, 2013, was mailed to MCPs and posted to the DHCS DRG webpage. It provides more detailed information regarding MCP payment for emergency and post-stabilization inpatient services by out-of-network hospitals.

8. How is payment calculated if a patient has Medi-Cal managed care in the first part of the stay and later becomes fee-for-service?

When billing a stay at a DRG hospital for a beneficiary who is covered by an MCP in the first part of the stay and later becomes fee-for-service during that same inpatient stay, the hospital must first obtain reimbursement from the MCP. When payment is received from the MCP, the hospital then bills the entire stay to FFS. The payment received from the MCP will be deducted from the total payment amount from FFS. Claims submitted for MCP and FFS must contain the following on the UB-04 claim form to receive reimbursement:

- Include prior payment dollar amount (amount paid by MCP) in the Prior Payments field (Box 54)
- Include one of the following statements in the Remarks field (Box 80):
  - Medi-Cal Managed Care and fee-for-service stay
  - Medi-Cal MC and FFS stay
- Attach the statement of payment from the MCP

DRG PAYMENT

9. How do DRG payment methods work?

In general, every complete inpatient stay is assigned to a single diagnosis related group (DRG) using a computerized algorithm that takes into account the patient's diagnoses, age, procedures performed, and discharge status. Each DRG has a relative weight that reflects the typical hospital resources needed to care for a patient in that DRG relative to the hospital resources needed to take care of the average patient. For example, if a DRG has a relative weight of 0.50 then that patient is expected to be about half as expensive as the average patient.

The DRG relative weight is multiplied by a DRG base price and any relevant policy adjustors to arrive at the DRG base payment. For example, if the DRG relative weight is 0.50 and the DRG base price is $8,000, then the payment rate for that DRG is $4,000.

10. How is the DRG assigned?

DHCS uses the 3M™ All Patient Refined Diagnosis Related Group algorithm (APR-DRG), to assign the DRG to each claim. Each stay is assigned first to one of 314 base APR-DRGs. Then, each stay is assigned a severity level (minor, moderate, major, or extreme). Severity depends on the number, nature and interaction of complications and comorbidities. For example, APR-DRG 139-1 is pneumonia, severity 1, while APR-DRG 139-2 is pneumonia, severity 2. Unlike Medicare DRGs, there is no universal list of complications and comorbidities.

The DRG methodology is updated annually, so it is critical to use the appropriate APR-DRG version to assign the DRG. Version 29 was used for Year 1 (claims with admission dates of 7/1/13 – 6/30/14, or FY 2013-14); Version 31 was used for Year 2 (claims with admission dates between 7/1/14 – 6/30/15, or FY 2014-15); Version 32 is used for Year 3 (claims with admission dates on or after 7/1/15, or FY 2015-16).

11. Where do the DRG relative weights come from?

DHCS uses APR-DRG relative weights calculated from the National Inpatient Sample. An analysis found very close correlation between the national weights and a set of weights calculated specifically from Medi-Cal fee-for-service data. The national weights are updated annually by 3M Health Information Systems. For FY 2015-16, the relative weights reflect hospital-specific relative value weights (HSRV) of V.32 of the APR-DRG grouper.

HSRV weights were chosen as they are a more accurate method of calculating relative weights that has been recently made available for APR-DRGs. HSRV weights are similarly calculated from the National Inpatient Sample, but control for differences among hospitals at charge levels.

12. What is the DRG base rate?

The DRG base rate is used in the DRG payment calculation as described in Question 9. Some hospitals are still in a transition period until all hospitals move to a statewide base rate on July 1, 2016. There are two statewide base rates – remote rural and non-remote rural. Hospitals fall into one of three categories for base rates:

- Non-transition hospital at the remote rural base rate
- Non-transition hospital at the non-remote rural base rate
- Transition hospital

In FY 2015-16, about one-third of California hospitals are paid using the statewide base rate of $6,289 ($12,768 for remote rural hospitals). For each hospital, the statewide base rate is adjusted for differences in local area wages, using the same approach and hospital-specific values as Medicare uses. (See Question 13.) In the Los Angeles area, for example, a typical FY 2015-16 statewide base rate is $7,436.

The other two-thirds of California hospitals are paid using hospital-specific transition base rates. The transition is intended to buffer the impact of the change in payment methods over a three-year period before full implementation July 1, 2016. For transition hospitals, rates for FY 2013-14 were set with the intention that a hospital's average payment per stay would increase or decrease no more than 5% relative to what it otherwise would have been for the same mix of patients. In FY 2014-15, DRG base rates were set with the intention that a hospital's average payment would change no more than 5% relative to Year 1. For FY 2015-16, a similar mechanism would apply relative to Year 2. (For NDPHs, the transition mechanism is similar, but the percentages are 2.5% in the period January-June 2014, 5% in FY 2014-15, and 7.5% in FY 2015-16.) Table 1 depicts the base rates over the first three years of DRG payment.

Hospitals can see their FY 2015-16 DRG base rates on the DRG webpage. In July 2013, each hospital was advised of its projected FY 2015-16 base rate. In June 2015, each hospital was advised of its final rate. For non-transition hospitals, the final rates differed slightly from the projections because the FY 2015-16 rates reflect the latest available Medicare wage area data adjusted by a factor of 0.9797 (see Question 13.) For transition hospitals, the final rates were the same as the projected rates.

For FY 2015-16, all hospitals designated as remote rural – both transition and non-transition – will be paid using a base rate 20% higher than it otherwise would have been. This supports access to care for beneficiaries in rural areas while maintaining the efficiency incentives of a DRG payment method. The remote rural base rate (used for non-transition hospitals) will be $12,768, up from $10,640 in FY 2014-15.

13. What are wage area index values and how are they used?

In implementing payment by DRG, the Department decided to vary the DRG base rate for each hospital depending on local area wage index values as determined by Medicare.

DHCS uses hospital-specific wage area index values as used by Medicare per the Medicare Impact File. For children's hospitals, critical access hospitals and other hospitals not included in the Medicare Impact File, DHCS uses the wage area index value (WI) that corresponds to the hospital's physical location. For FY 2015-16, the Medicare values have been multiplied by an adjustment factor of 0.9797. This factor adjusts for the increase in Medicare values for California relative to the rest of the country. The result is that Medi-Cal base rates are adjusted for changes in relative differences within California. Here is an example of the base rate calculation for a Los Angeles area hospital:

(*Statewide base rate* x *WI* x *labor share of WI* x *adjustment factor*) + (*Statewide base rate* x *non-labor share of WI*)

($6,289 x 1.2882 x 69.6% x 0.9797) + ($6,289 x 30.4%) = $7,436

14. Who else uses DRG payment?

The Medicare program implemented payment by DRG on October 1, 1983. About two-thirds of state Medicaid programs use DRGs, as do many commercial payers and various other countries. California and many other Medicaid programs use APR-DRGs, rather than Medicare DRGs, because APR-DRGs are much more appropriate for neonatal, pediatric and obstetric care. Medicare DRGs were designed for a Medicare population, where less than 1% of stays are for obstetrics, pediatrics, and newborn care. In the Medi-Cal fee-for-service population, these categories represent about two-thirds of all stays.

15. What are the characteristics of DRG payment?

- DRG payment defines "the product of a hospital," thereby enabling greater understanding of the services being provided and purchased.
- Because payment does not depend on hospital-specific costs or charges, this method rewards hospitals for improving efficiency.
- Because DRGs for sicker patients have higher payment rates, this method encourages access to care across the full range of patient conditions.
- DRG payment rewards hospitals that provide complete and detailed diagnosis and procedure codes on claims, thereby giving payers, policymakers, and hospitals better information about services provided.

16. What other payment policies affect payment methods?

For approximately 80% of stays, payment is made using a "straight DRG" calculation — that is, payment equals the DRG relative weight times the DRG base price, as described in Question 9. In special situations, payment may also include other adjustments, for example:

- *Policy adjustors.* Relative weights for neonates and pediatric stays are adjusted upward in order to facilitate access to care. As of July 1, 2015, obstetric stays are also adjusted upward through use of a policy adjustor.
- *Transfer pricing adjustment.* Payment may be reduced when the patient is transferred to another acute care hospital. The calculation is similar to the Medicare program, though the specific discharge status values differ. For details, see the DRG Pricing Calculator on the DRG webpage. Medi-Cal, unlike Medicare, does not have a post-acute transfer policy.
- *Cost outlier adjustment.* As do Medicare and other DRG payers, Medi-Cal makes additional "outlier" payments on stays that are exceptionally expensive for a hospital. Medi-Cal has a two-tier outlier policy. For a small number of stays that are exceptionally profitable for a hospital, Medi-Cal also has a "low-side" outlier policy that reduces payment. For details, see the DRG Pricing Calculator on the DRG webpage.
- *"Lesser Of."* If the allowed amount exceeds charges, payment is reduced to charges. This is consistent with previous policy.
- *Other health coverage and patient cost-sharing.* The calculations described above determine the allowed amount. From the allowed amount, Medi-Cal deducts payments from other health coverage (e.g., workers' compensation, etc.) as well as the patient's share of cost. Implementation of the DRG payment method did not affect these deductions.

17. What changes were made for FY 2015-16?

See Table 1 for a comparison of DRG payment policy between FY 2013-14, FY 2014-15, and FY 2015-16. The Department has kept the payment method as stable as possible during the three years of transition. For the first annual update impacting Year 2 of DRG payment, the changes were technical in nature rather than policy oriented. For the second annual update impacting Year 3 of DRG payment, technical changes as well as a few policy changes were made:

- A policy adjustor of 1.06 is applied to obstetric stays; this increases payments for obstetric stays.
- Remote rural hospitals – both transition and non-transition – are paid using a base rate 20% higher than it otherwise would have been.

- Wage areas for non-transition hospitals were updated and adjusted by a factor of 0.9797. This adjustment retains the relative positions of index values within California while removing the impact of relative changes between California and the rest of the country. Please refer to Question 13.
- HSRV weights are used as of July 1, 2015. Please refer to Question 11.

Table 1
Summary of DRG Payment Policies in Year 1 (FY 2013-14), Year 2 (FY 2014-15), and Year 3 (FY 2015-16)

Payment Policy	Year 1 Value (FY 2013-14)	Year 2 Value (FY 2014-15)	Year 3 Value (FY 2015-16)
DRG Base Rates			
DRG base rate, statewide	$6,223	$6,289	$6,289
DRG base rate, statewide (remote rural hospitals)	$10,218	$10,640	$12,768
Payment to non-transition hospitals	Statewide DRG base rate adjusted for Medicare FFY 2013 wage area values	Statewide DRG base rate adjusted for Medicare FFY 2014 wage area values	Statewide DRG base rate adjusted for Medicare FFY 2015 wage area values and the 0.9797 factor
Payment to transition hospitals	Hospital-specific, as shown in separate document[1]	Hospital-specific, as shown in separate document[2]	Hospital-specific, as shown in separate document[3]
Adjustment for wage area values	Similar to Medicare, reflecting a labor share of 68.8%	Similar to Medicare, reflecting a labor share of 69.6%	Similar to Medicare, reflecting a labor share of 69.6%, then adjusted by 0.9797 to neutralize CA changes compared to U.S.
Adjustment to base rates for improved documentation, coding and capture of diagnoses and procedures	-3.5%	None	None
DRG Grouper			
DRG version	APR-DRG V.29	APR-DRG V.31	APR-DRG V.32
DRG relative weights	APR-DRG V.29 (national, charge-based)	APR-DRG V.31 (national, charge-based)	APR-DRG V.32 (national, hospital-specific relative value (HSRV) weights)
National average length of stay benchmarks (used in calculating transfer adjustments)	APR-DRG V.29 (arithmetic, untrimmed)	APR-DRG V.31 (arithmetic, untrimmed)	APR-DRG V.32 (arithmetic, untrimmed)
Outlier Policy Factors			
Hospital-specific cost-to-charge ratios	Most recent available for Year 1, as determined by DHCS	FYE 2012 cost report (some exceptions may apply)	FYE 2013 cost report (some exceptions may apply)
High side (provider loss) tiers and marginal cost (MC) percentages[3]	$0-$40,000: no outlier payment	$0-$42,040: no outlier payment	$0-$45,000: no outlier payment
	$40,001 to $125,000: MC = 0.60	$42,041 to $131,375: MC = 0.60	$45,000 to $145,000: MC = 0.60
	>$125,000: MC = 0.80	>$131,375: MC = 0.80	>$145,000: MC = 0.80
Low side (provider gain) tiers and marginal cost percentages	$0-$40,000: no outlier reduction	$0-$42,040: no outlier reduction	$0-$45,000: no outlier reduction
	$40,000 to $125,000: MC = 0.60	$42,041 to $131,375: MC = 0.60	$45,000 to $145,000: MC = 0.60
Other Payment Policies			
Policy adjustor – neonate at designated NICU	1.75	1.75 (No change)	1.75 (No change)
Policy adjustor – neonate at other NICU	1.25	1.25 (No change)	1.25 (No change)

Table 1 Summary of DRG Payment Policies in Year 1 (FY 2013-14), Year 2 (FY 2014-15), and Year 3 (FY 2015-16)			
Payment Policy	**Year 1 Value (FY 2013-14)**	**Year 2 Value (FY 2014-15)**	**Year 3 Value (FY 2015-16)**
Policy adjustor – obstetric	n/a	n/a	1.06
Policy adjustor – pediatric miscellaneous, pediatric respiratory	1.25	1.25 (No change)	1.25 (No change)
Pediatric age cutoff	< 21	<21 (No change)	<21 (No change)
Discharge status values for the transfer adjustment	02, 05, 65, 66	02, 05, 63, 65, 66 (added 63)	02, 05, 63, 65, 66 (codes 82, 85, 91, 93, and 94 to be effective September 2015)

Notes:

1. For FY 2013-14 hospital-specific DRG base rates, see "SPCP Contract Rates" at www.dhcs.ca.gov/provgovpart/Pages/DRG.aspx.
2. For FY 2014-15 hospital-specific DRG base rates, see "SFY 14/15 Hospital Characteristics File" for non-transition hospitals and "SFY 14/15 Transition Base Rates for Admissions" for transition hospitals at www.dhcs.ca.gov/provgovpart/Pages/DRG.aspx.
3. For FY 2015-16 hospital-specific DRG base rates, see SFY 15/16 Hospital Characteristics File" for non-transitional hospitals and transitional hospitals base rates at www.dhcs.ca.gov/provgovpart/Pages/DRG.aspx.
4. Outlier thresholds have been increased to reflect the latest available data on hospital charge inflation.
5. For details of the pricing logic, APR-DRG groups, and relative weights, see the FY 2015-16 DRG Pricing Calculator at www.dhcs.ca.gov/provgovpart/Pages/DRG.aspx.

18. How will payments change in the future?

The Department plans an annual review of what changes, if any, in DRG base rates would be appropriate. Funding also depends on legislative appropriations. The combination of base rates, the number of stays, the average casemix per stay, and the service-specific and age-specific policy adjustors determines the overall level of payments.

In the early years of DRG payment, as the Department and the hospitals gain experience with the new method, it is possible that the Department will make adjustments to the payment method mid-year if necessary. If at all possible, any adjustments would be made on a go-forward basis. As of July 1, 2015, no retroactive adjustments have been necessary.

CODING AND BILLING

19. What are the most important billing points under DRG payment?

Table 2 shows the most important billing points under the DRG payment method, with specifics where appropriate to billing requirements, Treatment Authorization Requests (TAR), Service Authorization Requests (SAR) and business practices under the previous method.

Table 2 Impacts on Hospital Billing and Operations of the Change to DRG Payment July 1, 2013 (Listed in approximate declining order of impact)	
Item	**Comment**
Payment is per stay	Under DRG payment, one payment is made per stay. Under the previous method, payment was per day for contract hospitals and at a percentage of cost for non-contract hospitals.
TAR/SAR process	As of July 1, 2013, TAR/SAR is no longer required on length of stay for the vast majority of days. SAR is specific to CCS and GHPP recipients. For DRG-reimbursed hospitals, most inpatient stays require only an admit TAR, not a daily TAR. See Questions 28 and 30.
Increased importance of diagnosis and procedure coding	Assignment of the base APR-DRG and level of severity is driven by the number, nature and interaction of diagnoses and comorbidities as well as procedure codes. See Question 21.

Table 2 Impacts on Hospital Billing and Operations of the Change to DRG Payment July 1, 2013 (Listed in approximate declining order of impact)	
Item	**Comment**
Mother and newborn billed on separate claims	Separate payment is made for each patient. Under the previous method, normal newborns were billed on their mothers' claims.
Newborns with long lengths of stay and multiple claims must be billed with the same Medicaid number on each claim, preferably the baby's number	Because payment is by stay, submission of the mother's beneficiary number on some claims and the baby's beneficiary number on other claims would be problematic.
Newborn weight should be coded using diagnosis codes (not value codes) when applicable	This is important as birth weight is a critical input to the APR-DRG assignment. ICD-9-CM classification uses the 5th digit to indicate birth weight for diagnoses 764 and 765.0-765.1. Diagnosis codes should also be used to report gestational age where applicable.
Interim bill types 112, 113, and discharge status 30 only accepted for stays exceeding 29 days Interim bill type 114 not accepted	When the patient is discharged, a single admit-through-discharge claim should be submitted. See Question 31. For newborn claims, please be sure to consistently use the mother's or baby's beneficiary identification number for all claims related to a single stay.
Split billing a hospital stay (multiple-page paper claims)	This applies only to multiple-page paper claims. Each page of the claim must show all diagnosis and procedure codes. The provider number, beneficiary identification number, dates of admission, and all diagnosis and procedure codes should be the same on all pages.
Administrative days	Administrative days must be billed on a separate claim, identified by revenue code. Effective July 1, 2013, a new Level 2 administrative day was created to pay more than the existing Level 1 administrative day for sub-acute patients who require more care than Level 1. See Question 33.
Four-byte APR-DRG code	A hospital's billing system should accept a four-byte DRG code. An APR-DRG has three bytes for the base DRG and 1 byte for level of severity without the hyphen (format 1234 for DRG 123-4).
Physical rehabilitation stays	Physical rehabilitation days must be billed on separate claim, identified by revenue code. Payment is per diem. See Question 32.
Present-on-admission indicator	Submit claims with a valid present-on-admission value for each diagnosis (except for exempt diagnosis codes). See Question 23.
Separately payable services, supplies, and devices	In the few situations where separate payment is allowed, a separate outpatient claim should be submitted for bone marrow search and acquisition as well as blood factors. See Question 25.
Late charges (bill type 115) not accepted	Void and resubmit the original claim instead.
Health care-acquired conditions (HCACs)	Payment may be reduced if a HCAC is present on the claim. HCACs are also known as provider preventable conditions or PPCs under this federally required payment policy.
Physician services bundled into SPCP per diem rates	All physician services should be billed as professional claims (i.e., CMS-1500, 837P). Under the previous payment method, some hospitals had specific physician services bundled into the inpatient hospital per diem payment. See Question 26.
Transfers from non-contract hospitals	Under the DRG payment method, there is no distinction between contract and non-contract hospitals. All Health Facility Planning Areas are considered open areas allowing for all hospitals to serve Medi-Cal beneficiaries for all services (subject to approved Treatment Authorization Requests).
Patients with FFS and Medi-Cal managed care in the same stay	If the beneficiary has Medi-Cal Managed Care for the first part of the stay and then Medi-Cal fee-for service for the second part of an acute-care stay, then the hospital provider should bill the Medi-Cal Managed Care Plan first and obtain payment before billing fee-for-service. See Question 8.
CCS Patients with Medi-Cal fee-for-service	Most CCS patients also have Medi-Cal FFS. CCS inpatient stays are paid by DRG. Submit a single claim for a single payment; only an admission SAR or TAR is required. Daily authorization is required if the patient has a limited benefit aid code. See Questions 6 and 28.
CCS patients with Medi-Cal managed care	For a CCS client enrolled in a Medi-Cal managed care plan with "carved-out" CCS services, CCS authorizes inpatient admissions for the treatment of the client's CCS eligible condition. If a patient is treated for a CCS-eligible inpatient admission, submit the claim to Medi-Cal FFS and not the Medi-Cal managed care plan. See Questions 6 and 28.

20. In order to be paid, does my hospital need to buy APR-DRG software or put the DRG on the claim?

No. The Medi-Cal claims processing system assigns the APR-DRG to the claim and calculates payment.

21. How many diagnoses and procedures are used in DRG assignment? Why is this important?

The Medi-Cal claims processing system accepts up to 25 diagnosis codes and 25 procedure codes for electronic claims (18 diagnosis codes and 6 procedure codes for paper claims). Hospitals should bill all diagnoses and procedures related to a hospital stay to ensure that the appropriate base APR-DRG and patient severity of illness (SOI) are assigned.

22. For hospitals that are interested in using the APR-DRG grouper, what are some key grouper software settings used by Medi-Cal?

Table 3 shows common APR-DRG V.32 grouper settings used in the Medi-Cal DRG payment method. This information is provided specifically for hospitals that have the grouper and HAC utility software and need the settings used by DHCS to generate the APR-DRG assignment. Hospitals do not need this information in order to submit claims to Medi-Cal.

Table 3
Selected Grouper Settings for Medi-Cal

Grouper Field	Setting	Comments
APR-DRG Grouper Settings		
Grouper Version	V.32	Effective with dates of admission on or after July, 1, 2015.
Mapping Type	NA	APR-DRG V.32 was released October 1, 2014, reflecting the ICD-9-CM diagnosis and procedure code set that is effective between October 1, 2014, and September 30, 2015. 3M Health Information Systems, the developer of the APR-DRG software, advises that the mapper functionality will not be needed for V.32 between July 1, 2015, and September 30, 2015.
Birth Weight Option	Option 5 coded weight with default	Medi-Cal reads the diagnosis codes (not the value codes) to identify birth weight and/or gestational age if coded using appropriate diagnosis codes on the claim. If the claim does not include a diagnosis code indicating birth weight or gestational age, then the grouper default is to a birth weight that indicates "normal newborn."
Discharge DRG Option	Compute excluding non-POA complication of care	Excluding non-POA Complication of Care (default) is used.
Hospital-Acquired Condition (HAC) Utility Settings		
HAC Version	V.30	The current HAC utility, version 30, released January 2013, will remain in effect as of July 1, 2015.
Agency Indicator	CMS Medicaid	The January 2013 V.30 HAC utility defines pediatric as less than age 18. However, Medi-Cal policy defines pediatric as less than age 21. Current HAC policy requires that payment adjustments not be applied to Medicaid pediatric and obstetric populations within HAC Deep Vein Thrombosis/Pulmonary Embolism (DVT/PE), after certain orthopedic procedures. Medi-Cal is monitoring the application of payment adjustments within HAC category DVT/PE through post payment review. The goal is to ensure that the HAC rule is applied appropriately specifically for the DVT/PE category due to the conflict in the age definition of pediatric as referenced above. If DHCS finds that the rule for the DVT/PE HAC category is applied inconsistent with policy, the appropriate action is taken to ensure correct claims adjudication and payment.
Suppress HAC Categories	No HAC suppression is needed	Currently, the Department recognizes all of the Medicaid HAC categories. As a result, no category will be suppressed.
POA Indicators		For the present-on-admission (POA) diagnosis fields, no POA value (blank) is acceptable for exempt diagnosis codes. POA values W (clinically undetermined) and U (documentation insufficient) are treated in the claims processing system the same as value N (not present on admission).

23. Is the present-on-admission indicator required?

Yes. Hospitals are required to include the present-on-admission (POA) indicator associated with the principal and secondary diagnosis codes when submitting paper and electronic claims. Hospitals should submit valid values of the POA indicator. These values are used to identify health care-acquired conditions (Question 23). For the official guidelines on how to apply the POA indicator as well as information on complete and accurate documentation, code assignment and reporting of diagnoses and procedures, see http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Coding.html.

24. How is payment affected if a health care-acquired condition is present on the claim?

Federal law requires Medicaid programs to demonstrate that they are not paying for "health care-acquired conditions (HCACs)," as defined specifically by CMS. The list is virtually identical to the Medicare hospital-acquired condition (HAC) list that hospitals are already familiar with. The Medi-Cal claims processing system identifies HCACs from the diagnosis, procedure and present-on-admission information on the claim and disregards the HCAC in assigning the APR-DRG. Therefore, payment for the stay would be affected only if the presence of the HCAC would otherwise have pushed the stay into a higher-paying APR-DRG. Based on an analysis of data from Medi-Cal, Medicare and other states, we expect payment to be reduced on less than 1% of stays. (This figure could change if CMS expands the list of HCACs.)

For FY 2015-16, Version 30 of the health-care acquired conditions utility continues to be used because it includes the conditions added by CMS effective October 1, 2012.

25. Are outpatient services related to the inpatient stay bundled?

In general, the Medi-Cal distinction between outpatient and inpatient services (e.g., when a patient receives outpatient emergency or diagnostic services on the day of admission) is the same under DRG payment as it was previously. One exception is that prior to July 1, 2013, a few hospitals could bill for a short list of specialized, high-cost services (e.g., blood factors) on an outpatient claim even when provided on an inpatient basis. Under the DRG payment method, all hospitals are able to bill the items in Table 4 on an outpatient claim for separate payment during an inpatient stay; please note the additions to this list as of July 1, 2015.

Table 4
Separately Payable Services That Can Be Billed on an Outpatient Claim

Description	CPT / HCPCS Code Effective July 1, 2013-June 30, 2015	CPT / HCPCS Code Effective July 1, 2015[1]
Bone Marrow Search and Acquisition Costs		
Management of recipient hematopoietic progenitor cell donor search and cell acquisition	38204	38204
Unrelated bone marrow donor	38204	38204
Blood Factors		
Blood Factor XIII (antihemophilic factor, Corifact)	J7180	J7180
Blood Factor XIII (antihemophilic factor, Tretten)		C9134
Blood Factor Von Willebrand- Injection	J7183 / J7184 / Q2041	J7183 / J7184 / Q2041
Blood Factor VIII	J7185 / J7190 / J7192	J7185 / J7190 / J7192
Blood Factor VIII/Von Willebrand	J7186	J7186

Table 4 Separately Payable Services That Can Be Billed on an Outpatient Claim		
Description	**CPT / HCPCS Code Effective July 1, 2013-June 30, 2015**	**CPT / HCPCS Code Effective July 1, 2015[1]**
Blood Factor Von Willebrand	J7187	J7187
Blood Factor VIIa	J7189	J7189
Blood Factor IX	J7193 / J7194 / J7195	J7193 / J7194 / J7195
Blood Factor Antithrombin III	J7197	J7197
Blood Factor Antiinhibitor	J7198	J7198
Hemophilia clotting factor, not otherwise classified		J7199
Long-Acting Reversible Contraception (LARC) Methods		
Intrauterine copper (Paraguard)		J7300
Skyla		J7301
Levonorgestrel-releasing intrauterine contraceptive system (Mirena)		J7302
Etonogestrel (Implanon, Nexplanon)		J7307

Note:

1. These services can be billed separately as of July 1, 2015. Please watch for a bulletin that may address instructions for retroactive adjustment of claims for these new LARC codes beginning January 1, 2015.

26. How did the implementation of DRG pricing affect contracted SPCP rates that bundled the physician component of hospital services with the hospital component?

Effective July 1, 2013, the physician component always should be separately billed on a professional (e.g., CMS-1500) claim. This situation only affects a few hospitals that previously had negotiated bundled physician/hospital payments for specific services.

27. How would the hospital indicate a situation of partial eligibility?

A situation of partial eligibility during a hospital stay is not affected by DRG payment. Hospitals should bill for the portion of the stay for which the patient has Medicaid eligibility.

28. What is the impact on billing and the TAR/SAR process for CCS patients?

CCS and Fee-for-Service (FFS) Medi-Cal: As mentioned in Question 6, claims for beneficiaries under CCS are priced using the DRG methodology. Most CCS patients also have Medi-Cal coverage. CCS and Medi-Cal Billing and the SAR/TAR process have been streamlined for these patients. Separate claims and authorizations for the CCS and Medi-Cal parts of the stay are no longer required if the beneficiary has Medi-Cal FFS. Only one claim should be submitted, and only one admission SAR or TAR should be requested for a CCS client, including for clients with limited scope Medi-Cal, i.e., pregnancy related and emergency services only. One DRG payment is made for the stay.

CCS and Medi-Cal Managed Care: For a CCS client enrolled in a Medi-Cal managed care plan with "carved-out" CCS services, CCS will issue a SAR for inpatient admissions for the treatment of the client's CCS eligible condition. If CCS authorizes the admission with a SAR, Medi-Cal FFS should be billed pursuant to the CCS SAR and the services will be reimbursed using DRG methodology. If the

client is not CCS medically eligible on admission and CCS subsequently determines that the client is CCS medically eligible at any point in the inpatient episode, CCS will issue a SAR covering the entire inpatient episode. The resulting claim should be submitted to Medi-Cal FFS and not to the Medi-Cal managed care organization.

Payment for all inpatient services for a CCS client enrolled in a Medi-Cal managed care plan with "carved-in" CCS services, i.e., the County Organized Health System health plans in San Mateo, Santa Barbara, Solano, Yolo, Marin, and Napa counties, are the responsibility of the Medi-Cal managed care plan and should not be billed to Medi-Cal FFS.

29. When and how will ICD-10 affect the DRG payment method?

Nationwide ICD-10 implementation is expected October 1, 2015. At that time, the Medi-Cal claims processing system will accept ICD-10 diagnosis and procedure codes and will utilize ICD-10 codes for internal processing. ICD-10 codes will be mapped to ICD-9 codes using the 3M APR-DRG mapper, and then the DRG will be assigned. Hospitals should follow national guidelines in submitting ICD-10 codes to Medi-Cal.

TREATMENT AUTHORIZATION

30. How does DRG payment fit with the Treatment Authorization Request (TAR) and Service Authorization Request (SAR) processes?

Simplification of the TAR/SAR process was a major benefit of DRG implementation July 1, 2013. Note: SAR is specific to California Children's Services (CCS) and Genetically Handicapped Persons Program (GHPP) recipients.

For stays paid by DRG, the TAR/SAR process is as follows:

- Continuation of the previous TAR/SAR requirements on the medical necessity of the admission, including CCS and GHPP admissions. That is, authorization is required for all admissions except for deliveries and care of well babies (i.e., normal newborns).
- Discontinuation in almost all cases of the previous TAR/SAR requirement on the length of stay. However, beneficiaries with restricted aid codes who have an admission that does not involve a delivery or well-baby care continue to require a TAR with review of all hospital days. (For beneficiaries with restricted aid codes, this is a continuation of the previous process.)
- Continuation of the previous TAR requirement for a short list of specific procedures for all beneficiaries.
- Prior to submission of an interim claim, please submit a TAR/SAR for approval. Payment of interim claims requires an approved admission TAR/SAR.
- Either a SAR or TAR, based on eligibility at admission, is required if a patient has a stay that is covered by CCS and Medi-Cal. See Question 28.

For stays not paid by DRG:

- TAR requirements on both the admission and the length of stay continue as they were previously for rehabilitation and administrative days (see Questions 32 and 33).
- Designated public hospitals (DPHs) follow their previous process.

SERVICES NOT PAID BY DRG

31. How are interim claims paid?

Hospitals are never required to submit interim claims but can choose to do so if the date span exceeds 29 days. In these situations, the hospital is paid a per diem amount ($600). When the patient is discharged, the hospital submits a single, admit-through-discharge claim. Hospitals should not send void claims. Final payment is calculated by the DRG method and then reduced by the interim claim amounts that were previously submitted. Payment of interim claims is unusual among DRG payers, but helps ensure access to care for sick newborns and other patients with unusually lengthy stays. Payment of interim claims requires an approved admission TAR/SAR.

32. How are physical rehabilitation services paid?

Physical rehabilitation services — either within a general acute care hospital or a specialty rehabilitation facility — are not paid by DRG. Instead, DHCS has established per diem rates for each hospital. Each hospital has a specific rate based on its historical blend of pediatric and adult days using statewide rates of $1,841 (pediatric) and $1,032 (adult), adjusted for the hospital's Medicare wage area. These rates are the same for Year 3 as in Year 2, although hospital-specific rehabilitation rates in Year 3 were affected by a change to neutralize the increase in California wage values compared to the rest of the United States. This 0.9797 factor adjustment was applied to the labor portion of the wage area.

For FY 2015-16, these rates are the same as FY 2014-15, though the update in wage area index values will affect rates for individual hospitals. Hospital-specific rates are available on the hospital characteristics tab of the DRG pricing calculator that is available on the DRG webpage.

Rehabilitation services are identified by claims that include revenue codes 118, 128, 138, and/or 158. For hospital stays without these revenue codes that group to the rehabilitation DRG (860), the claim is denied and the hospital must resubmit the claim with the appropriate revenue codes or primary diagnosis (if rehabilitation was incorrectly listed as the principal diagnosis on the original claim). No claims are priced using DRG code 860. Daily TAR is required for rehabilitation services.

33. How are administrative days paid?

Generally, administrative days are defined as days of service provided to beneficiaries who no longer require acute hospital care, but need nursing home placement or other subacute or post-acute care that is not available at the time. Administrative days are approved through the TAR/SAR process and paid at a lesser of the average statewide per diem equivalent to the cost of Distinct Part-Skilled Nursing Facility (DP-SNF) services or the hospital's actual DP-SNF cost. As of July 1, 2013, the Department implemented two levels of administrative days.

- Level 1: Please refer to the Administrative Days Level 1 document from the Medi-Cal's Provider manual Part 2- Inpatient Services (IPS-Administrative Days (admin) section) in the Publications tab or directly at http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/admin_i00.doc for up to date information.
- Level 2: This is a new level, similar to level 1, except at a higher rate for higher acuity patients. Administrative day level 2 care is defined as care that is less intensive than acute care, and more intensive than level 1:
  - Administrative day level 2 revenue codes 190 (sub-acute pediatric) and 199 (sub-acute adult) are available for payment only to DRG hospitals. The pediatric level is used when the beneficiary is less than 21 years old. Administrative day level 2 requires a daily TAR and submission of a claim separate from the DRG claim. Payment for administrative day level 2 is the lower of the hospital-

specific rate already established and the statewide rate. As of July 1, 2015, Year 3 statewide per diem rates are $981.63 (pediatric) and $805.82 (adult). Payment works the same as revenue code 169 relative to bundling policies and separate payment for ancillary services.

The previous list of separately payable services that can be billed in conjunction with administrative days is unchanged.

34. What is the relationship between DRG payment and hearing or other screenings hospitals are required to perform on all newborns?

Implementation of DRG payment did not affect health screening requirements for newborns. Additional information on the existing process for newborn health screens is available at https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/newborn_a02a08i00o03o11m01.doc.

35. What changes, if any, were made to supplemental payments?

Medi-Cal has several programs under which it makes supplementary payments to hospitals, e.g., disproportionate share hospital replacement payments, hospital fee payments, and private hospital supplemental fund payments. These payments are unaffected by the transition to DRG payment.

OTHER QUESTIONS

36. How did the change to DRG payment affect the overall payment level?

The change to DRGs was a change in payment method, not payment level. The overall payment level continues to be determined each year through the legislative appropriation process.

37. How did the change affect funding to each hospital?

Because there was a major change in the payment method, some hospitals saw decreases in payments while other hospitals saw increases. There is a transition period of three years; see Question 12.

38. Are DRG payments subject to adjustment after cost reports have been submitted?

In general, payments are not subject to adjustment after the DRG payment has been made. That also applies to hospitals that were non-contract prior to July 1, 2013, and to hospitals classified by Medicare as critical access. The Department reserves the right to audit claims if appropriate. For example, the Department may audit stays that receive an outlier payment, have restricted aid codes, or inappropriate coding.

39. Do hospitals still have to submit cost reports?

Yes. The Department utilizes cost reports for a variety of purposes, including calculation of hospital utilization fees, establishing a cost-to-charge ratio (CCR) used in DRG outlier payment policy, and review of hospital payments overall.

FOR FURTHER INFORMATION:

40. Where can I go for more information?

The DHCS webpage at http://www.dhcs.ca.gov/provgovpart/Pages/DRG.aspx is the best source for information. Resources include:

- *FAQ*. Updates of this *Frequently Asked Questions* are made available as changes are needed. In addition, DHCS has compiled an additional Provider Billing FAQ specific to billing and TAR/SAR issues compiled from questions from hospitals.
- *DRG Pricing Calculator*. The DRG Pricing Calculator interactive spreadsheet does not assign the APR-DRG, but it demonstrates how a given APR-DRG is priced in different circumstances. The calculator includes a complete list of APR-DRGs and related information for use in California. Please select the appropriate DRG calculator based on admission date within the appropriate fiscal year.
- *Hospital training sessions.* Hospital trainings were held across the state prior to DRG implementation and since implementation. If additional training is needed, please contact the Medi-Cal Telephone Service Center (TSC) 1-800-541-5555 or email DRG@dhcs.ca.gov.
- *Provider Bulletins.* Provider bulletins contain additional details on specific areas of DRG billing, payment, and TAR/SAR authorizations.

Other key resources are as follows:

- *Questions:* For policy questions, please email the DRG mailbox at *DRG@dhcs.ca.gov*. Please be sure not to send any patient-specific information by email.
- *DRG listserve:* To subscribe to the DRG listserve, email *DRG@dhcs.ca.gov*
- *Medi-Cal provider manual.* The manual was updated to show billing details for the DRG based payment method and is available on the DHCS webpage at http://files.medi-cal.ca.gov/pubsdoco/manuals_menu.asp
- *Recorded trainings.* Providers may access recorded trainings on the Xerox Provider training site (login, then go to Training > Recorded Webinars) or go to https://learn.medi-cal.ca.gov/Login/tabid/87/Default.aspx?returnurl=%2fTraining%2fRecordedWebinars.aspx